MDR: M4-02-2970-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement for date of service 07/27/01.
   b. The request was received on 03/29/02.

II. EXHIBITS

1. Requestor, Exhibit I:
   a. TWCC 60
   b. HCFA-1500
   c. EOBs
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:
   a. Response to a Request for Dispute Resolution
   b. HCFA-1500
   c. EOBs
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Based on Commission Rule 133.307 (g) (4), the Division notified the insurance carrier Austin Representative of their copy of the requestor's additional information being submitted on 06/26/02. The insurance carrier did not submit a response to the additional information. The carrier's initial response dated 05/21/02 is reflected in Exhibit II of the Commission's Case File. The provider's initial request for medical dispute submission was date stamped received by TWCC on 03/29/02. The MR-100 letter notifying the carrier of the provider's initial dispute submission was mailed to the carrier on 05/10/02.

4. Notice of Additional Information Submitted by the Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: No position statement (Table of Disputed Services Rationale): "Appeal denied not supporting level of service, however notes will reflect interdisciplinary team action. Remainder of program has been paid."

2. Respondent: Letter dated 05/17/02:
"This will acknowledge your notice of the Medical Dispute Resolution requested by (Provider) for Date of Service 07/27/01. We have been unable to locate a copy of the initial request for Medical Dispute Resolution filed by the Requestor in this case. The carrier's position is well documented in the EOBs filed per the review by (Review Company) on 12/08/01 and 03/12/02."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 07/27/01.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer. Per the provider's TWCC-60, the amount billed is $455.00; the amount paid is $0.00; the amount in dispute is $448.00.

3. The carrier denied the billed services by codes, "N – NOT APPROPRIATELY DOCUMENTED REPORT SUBMITTED DOES NOT APPEAR TO SUBSTANTIATE LEVEL OF SERVICE BILLED." and "D – DENIAL AFTER RECONSIDERATION, N – NOT APPROPRIATELY DOCUMENTED RE-EVALUATION NO ADDITIONAL RECOMMENDED ALLOWANCE."

4. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
07/27/01	97545-WHAP 97546-WHAP	$130.00 (billed 2 hrs) $325.00 (billed 5 hrs)	$0.00 $0.00	N,D N,D	$64.00 an hr. per hour	Rule 133.1 (a) (E) (i); MFG MGR (II) (A), (C), (E), (E) (4), (E) (5), (E) (6), (E) (7) (a-e), (E) (8); CPT descriptor	Rule 133.1 (a) (E) (i) requires that that all supporting documentation be legible and include "for …interdisciplinary teams such as…work hardening programs…a copy of progress notes and/or SOAP (subjective/objective assessment plan/procedure) notes, which shall substantiate the care given and the need for further treatment(s) and/or services(s), and indicate progress, improvement, the date of the next treatment(s) and/or services(s), complications, and expected release dates,…"

							The provider submitted one generic appearing progress note written by an "OTR" dated "7-27-01" which noted a checklist of the hours which are available at the clinic under ___. The number of hours the patient attended for the day of service are checked at the top of the page next to the CPT code billed and totaled in the column labeled "**Total Hours:**.". The provider did indicate subjective pain level for "am" and "pm". Subjectively, the patient states that she is having "↑'ed pain in L Leg & hip. She reports this pain feels better p she gets her body 'warmed up'." The "**Objective**" section lists tasks the patient completed. The comment stated "see exercise flow sheet for details". The "**Assessment**" section reports "Pt presented ć bright affect upon arrival. She is demonstrating good motivation to complete exercise & work sim [sic] activities. She appears to be feeling more comfortable ć peers & staff although still (illegible word) review of documentation (illegible word)." The patient Plan is to increase ROM, Strength, Endurance, Cardiovascular Activity, Lift/Carry/PDL capacities, and work simulation activities. The provider does address subjective, objective, assessment, and plan areas on the progress note submitted for DOS 07/27/01. The provider did document that the patient "feels better", but the "Assessment" fails to assess the patient's progress, improvement, or problems with the work hardening exercise and work simulation programs. The provider failed to document the next date of treatment or service, an expected release date or the need for further treatment. The provider failed to submit documentation that indicates how long the patient has been in the program. Without any documentation of progress, improvement, or complications, the provider failed to substantiate the level of service being given to the patient. MFG MGR (II) (A), (C), and (E) describe a Work Hardening Program as a program in which services are performed by an interdisciplinary core team and may be accredited by CARF. If the program is CARF accredited, the program bills with the modified "-AP". If the interdisciplinary program is not CARF approved, the hourly reimbursement is reduced by 20% below the MAR value listed in the ground rules. MFG MGR (E) (4) and (E) (5) indicate Work Hardening CPT code 97545-WH is billed for the first two hours and 97546-WH is billed for each additional hour and the reimbursement rate for the program is $64.00 per hour. The provider billed with the correct CPT codes and modifiers. The only documentation which notes any other professionals with this program is a "**Work Hardening Daily Activity Report**" with the "**START DATE:** 7/24/2001" and "**WEEK OF** 7/23 **TO** 7/27 2001". The date of "7/27" is written over the date "7/26". The abbreviation "**WK#__**" has a "\" through the line. The signatures at the bottom of the page include a "___", "PhD", and another "___".

							MFG MGR (E) specifically details the Work Hardening Program as "A highly structured, goal-oriented, individualized treatment program designed to maximize the ability to the persons served to return to work…programs are interdisciplinary…with the capability of addressing the functional, physical, behavioral, and vocational needs of the injured worker. Work Hardening provides a transition between management of the initial injury and return to work while addressing the issues of productivity, safety, physical tolerances, and work behaviors. …programs use real or simulated work activities in a relevant work environment in conjunction with physical conditioning tasks." MFG MGR (E) (6), (7) (a-e) states that "An individualized plan of treatment shall be supervised by an licensed physical or occupational therapist and/or doctor within a therapeutic environment. Although some time is spent with the physical therapist, occupational therapist, or doctor on a one-to-one basis, more than 50% of the time is self-monitored under the supervision of a licensed member of the interdisciplinary team." Program supervision is provided by a licensed physical/occupational therapist or doctor and the supervisor shall… "provide direct on-site supervision of work hardening activities; …participate in the initial and final evaluation of the patient;…write the treatment plan for the patient and write changes to the plan based on documented changes in the patient's condition;…direct the interdisciplinary team when providing treatment and services;…review the patient's progress on a systematic basis." (E) (8) says that "daily treatment and the patient's response to treatment shall be documented and reviewed to ensure continued progress." The patient's treatment plan is not individualized or goal-oriented toward the patient. There is one mention of the patient's left leg and hip, but no other documentation of the patient's prognosis. Page one of the daily activity notes signed by an "___" addresses the exercise program with the dates written at the top of the page, but not written on each day of the week column which lists each activity. The activity report fails to document the duration of each activity. The activities on the second activity report signed by three individuals has a variety of activities which could be considered "work" related, but since the provider fails to address the patient's job duties when the injury occurred, there is no way to determine if the program is providing a transition between the management of the initial injury and the patient's return to work. The provider's documentation fails to address issues of productivity, safety, physical tolerance, and work behaviors. Both activity reports fail to document the duration of each activity, therefore, not substantiating the services rendered as billed on the HCFA-1500. The dates are written at the top of the page, but not on each day of the week column which lists each activity. The activity report fails to document the duration of each activity.

							The provider's documentation fails to report when the patient began the program, thus, not meeting the criteria of measuring the patient's progress of daily treatment and patient response to treatment. There is no documentation submitted which indicates the patient's continued progress or complications which would mean the treatment plan would require changes based on the patient's condition or lack of progress. There is no documentation that the patient's program is reviewed on a systematic basis. The provider's documentation fails to substantiate the level of service billed. Without the time factor of the duration of each activity being documented by the provider, the amount of time being billed for services rendered cannot be substantiated, therefore, no reimbursement is recommended.
Totals		$455.00	$0.00				The Requestor **is not** entitled to reimbursement.

The above Findings and Decision are hereby issued this 18th day of October 2002.

Donna M. Myers
Medical Dispute Resolution Officer
Medical Review Division

DMM/dmm